Georgetown Internal Medicine
Patient Authorization

I, _____, hereby authorize Georgetown Internal Medicine, to use and/ or disclose my protected health information described below to:

_____
_____
_____

For the purpose of:

_____
_____

This authorization for use and/or disclosure applies to the information described below (mark those that apply):

- ☐ Any and all records in the possession of the Practice including mental health, HIV, and/or substance abuse records. (Cross any item you do not authorize to be released)
- ☐ Records regarding treatment for the following conditions or injury _____ on or about _____.
- ☐ Records covering the period of time_____to_____.
- ☐ Other (please specify – include dates) _____.

Patient Date of Birth: _____ Patient Social Security No.: _____

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Georgetown Internal Medicine, 1138 Lexington Road, Suite 290, Georgetown, KY 40324. I also understand that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization.

I understand that I do not have to sign this authorization and that the Practice may not condition treatment or payment on whether I sign this authorization.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal laws and regulations regarding the privacy of my protected health information.

This authorization expires on (please list a specific date or event)_____. If no date or event is provided by the patient, this authorization will expire on year from the date signed.

I certify that I have received a copy of this authorization.

_____ _____
Signature of Patient or Personal Representative Date

_____
Name of Patient or Personal Representative

_____
Description of Personal Representative's Authority